LECHNER CHIROPRACTIC

PATIENT INFORMATION

Name: _____ SSN: _____-_____-_____ DOB: _____ AGE: _____

Address: _____ City: _____ State: ____ Zip: _____ Marital: M S W D

Home Phone #: _____ Cell Phone #: _____ Race: _____ Sex: M F

Occupation: _____ Employer: _____ Employer Phone #: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Email: _____ How did you hear about us? :_____

ACCIDENT INFORMATION

Is this condition due to an accident: ___Yes ___No If yes date of accident: _____

Type of accident: ___Auto ___Work ___Home ___Other: _____

To whom have you made a report of you accident: __Auto Insurance ___Employer ___Worker Comp ___Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for visit: _____

When did your symptoms appear? _____ Is it getting progressively worse? _____

Rate the severity of your condition on a scale of 1 (mild) – 10 (very severe) _____

Type of pain: __Sharp __Dull __Throbbing __Numbness __Aching __Shooting __Burning __Tingling

__Cramps __Stiffness __Swelling __Other:_____

How often do you have this pain? _____

Is it constant, or does it come and go? _____

Does it interfere with your :

__Work __Sleep __Daily Routine __Recreation

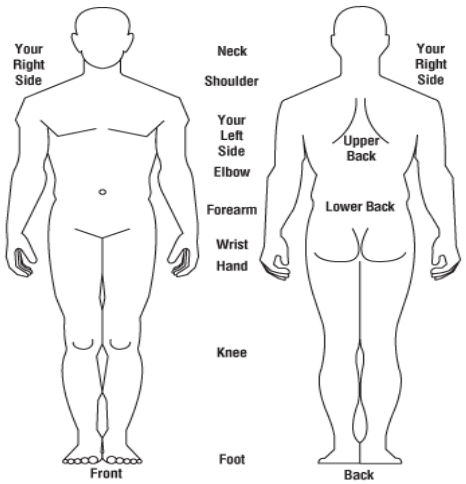
__Other: _____

Activities or movements that are painful to perform:

__Sitting __Standing __Walking __Bending __Laying Down

__Other: _____

Please mark an "x" on the picture below where you continue to have pain, numbness, or tingling.



HEALTH HISTORY

What treatment have you already received for your condition? __Medications __Surgery __Physical Therapy

__Chiropractic Services __None __Other: _____

Name and contact information for other doctor(s) who have treated your condition: _____

_____

Date of Last: Physical Exam: _____ Spinal X-Ray: _____ MRI, CT- Scan: _____

Spinal Exam: _____ Chest X-Ray: _____ Bone Scan: _____

Please mark an "X" to indicate if you ***HAVE HAD*** any of the following:

__Broken or Fractured Bones __Osteoarthritis __Eating Disorder __Circulatory Problems __Epilepsy

__Alcoholism __Rheumatoid Arthritis __**Pace Maker** __Drug Addiction __Seizures/Convulsions

__Strokes __HIV Positive __A Congenital Disease __Cancer __Gall Bladder __Excessive Bleeding

__Ruptures __Depression __High Blood Pressure __Low Blood Pressure __Coughing Blood

__Ulcers __Diabetes __Asthma __Other: _____

ARE YOU PREGNANT: ___ Yes ___No **ARE YOU ALLERGIC TO ANYTHING:** __Yes __No

If yes then describe: _____

What medications are you taking (if any): _____

Exercise:	**Work Activity:**	**Habits:**	**Injury/Surgeries:**
__None	__Sitting	__Smoking	Falls: _____
__Moderate	__Standing	__Alcohol	Head Injuries: _____
__Daily	__Light Labor	__Coffee/Caffeine Drinks	Broken Bones: _____
__Heavy	__Heavy Labor	__High Stress Level	Surgeries: _____

INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to Patient: _____

Insurance Co.: _____ ID #: _____ Group #: _____

Name of Secondary Insurance Company if any: _____ ID #: _____

Subscriber: _____ DOB: _____ Relationship to Patient: _____

AUTHORIZATION AND RELEASE

I, authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health History Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: __ _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____